MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10332

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Henryton
LENGTH OF STAY (in this place) 7mos. 3das.
HOSPITAL OR INSTITUTION OR STREET ADDRESS HENRYTON STATE HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore-13
STREET ADDRESS (If rural give location) 2208 W. Lanvale St. ✓

3. NAME OF DECEASED: (Type or Print) (First) JOHN (Middle) ALBERT (Last) ALEXANDER, JR.
4. DATE OF DEATH: (Month) (Day) (Year) January 16, 1953
5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: 11-29-1929
9. AGE last birthday: 23 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION..Give kind of work done during most of working life, even if retired): Porter
10b. KIND OF BUSINESS OR INDUSTRY: Md. Casualty Co.
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John Alexander, Sr.
14. MOTHER'S MAIDEN NAME: Hilda Simms
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 217-24-7273
17. INFORMANT & ADDRESS: Deceased

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Far Advanced Bilateral Cavitary Pulmonary Tbc. — Interval Between Onset And Death: March, 1950

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 19, 1952, to Jan. 16, 1953, that I last saw the deceased alive on Jan. 16 1953, and that death occurred at 6:25 p.M., from the causes and on the date stated above.
SIGNATURE I F Vestal M.D (Degree or title)
ADDRESS Henryton, Maryland
DATE SIGNED 1-16-53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 1/21/53
NAME OF CEMETERY OR CREMATORY Mt Auburn
LOCATION (City, town, or county) (State) Baltimore City
DATE REC'D BY LOCAL REGISTRAR 1-16-53
REGISTRAR'S SIGNATURE Albert R. Swarthout Deputy Local
24. FUNERAL DIRECTOR Geo. B. Kelson
ADDRESS 1303 Presstmans Av

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 22 1993
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

00333

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 76

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Carroll; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Finksburg; LENGTH OF STAY (in this place) 1 year; HOSPITAL OR INSTITUTION OR STREET ADDRESS Finksburg Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE West Va. COUNTY Jefferson; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bakerton; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
HARRY	Lee	ALLEN	Jan	11	1953

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Widower	Nov. 10, 1874	78 yrs.	2			

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Limestone Quarry	Sandy Hook, Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William Allen	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No None	Unknown	Mrs. Herman Snyder Bakerton, West Virginia

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
490X Immediate cause (a) Lobar Pneumonia	4 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Diabetes Mellitus	years
(260X) (c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Jan, 1952, to Jan 11, 1953, that I last saw the deceased alive on Jan 10, 1953, and that death occurred at 8:30 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
James T Marsh	M.D.	Westminster Md	1/11/53

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Removal	1/11/53	Samples Manor Cemetery	Washington County,	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1/11/53	[illegible]	Donald Eckles	Bolivar, W. Va.

RECEIVED
JAN 12 1953
BUREAU V. S.

Item 9 FilmG150 1/26/53 whw

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

60334

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH: COUNTY Carroll; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster; LENGTH OF STAY (in this place) 72 yr.; HOSPITAL OR INSTITUTION OR STREET ADDRESS R. D. 4

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Carroll; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster; STREET ADDRESS (If rural, give location) R. D. 4

3. NAME OF DECEASED (Type or Print): (First) EDWARD (Middle) ANTHONY (Last) ARNOLD

4. DATE OF DEATH: (Month) January (Day) 14 (Year) 1953

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: Dec. 18 1883

9. AGE last birthday: 72 69 yrs. If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Farmer - own farm

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Elias Arnold

14. MOTHER'S MAIDEN NAME: Flora S. Osterhaus

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Walter E. Arnold Westminster Rd 4 Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cardio Vascular Renal disease	10–15 yrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Myocardial degeneration &	
	(c) Vulgar Insufficiency Arteriosclerosis	

4427

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1945, to Jan 14, 1953, that I last saw the deceased alive on Jan 13, 1953, and that death occurred at 11:30 A.m., from the causes and on the date stated above.

SIGNATURE: Glenn Specker (Degree or title) ADDRESS: Md Westminster Md DATE SIGNED: 1/15/53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: Jan 17 1953

NAME OF CEMETERY OR CREMATORY: Deer Park Cemetery

LOCATION (City, town, or county): Smallwood (State): Md.

DATE REC'D BY LOCAL REG.: 1/16/53

REGISTRAR'S SIGNATURE:

24. FUNERAL DIRECTOR: H Bankard & Son Westminster, Md. ADDRESS

RECEIVED
JAN 10
BUREAU V. I.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 (0335

CERTIFICATE OF DEATH

Reg. Dist. No. 76

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Patapsco
LENGTH OF STAY (in this place) 16 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Patapsco
STREET ADDRESS (If rural give location) —

3. NAME OF DECEASED: (Type or Print) (First) GLENN (Middle) FRANKLIN (Last) BLIZZARD

4. DATE OF DEATH: (Month) (Day) (Year) Jan 22 19 53

5. SEX: M | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single | 8. DATE OF BIRTH: Jan 8-1937 | 9. AGE last birthday: 16 yrs. | IF UNDER 1 YEAR: Months Days | IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Student

10b. KIND OF BUSINESS OR INDUSTRY: High School

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Roscoe H Blizzard

14. MOTHER'S MAIDEN NAME: Amelia L Lykes

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) | (If Yes, give war or dates of service) —

16. SOCIAL SECURITY No.: —

17. INFORMANT & ADDRESS: Roscoe H Blizzard, Patapsco Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Pulmonary Embolism — Interval Between Onset And Death: Suddenly

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Rheumatic Cardio Vascular disease — ?

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURED While at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 19, 19 53 to Jan 22, 19 53, that I last saw the deceased alive on Jan 21, 19 53, and that death occurred at 8:45 A.M., from the causes and on the date stated above.

SIGNATURE Dr. Bush (Degree or title) | ADDRESS Hampstead Md | DATE SIGNED Jan 22, 53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF Jan 25/53 | NAME OF CEMETERY OR CREMATORY Wesley Cem | LOCATION (City, town, or county) Carroll Co (State) Md

DATE REC'D BY LOCAL REGISTRAR January 23, 1953 | REGISTRAR'S SIGNATURE Ruth E. Lewis Dep. Registrar | 24. FUNERAL DIRECTOR Elder Clifton | ADDRESS Hampstead Md

L.F. Woodward-exc

RECEIVED
JAN 29 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00336

Reg. Dist. No. 24

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville
LENGTH OF STAY (in this place) since 10/26/51
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY ---
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City
STREET ADDRESS (If rural give location) 514 S. Hanover Street ✓

3. NAME OF DECEASED: (Type or Print) (First) John (Middle) J. (Last) BRITNER

4. DATE OF DEATH: (Month) January (Day) 14 (Year) 1953

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Unk-

8. DATE OF BIRTH: Unk. 1900

9. AGE last birthday: 53 yrs. IF UNDER 1 YEAR Months 3 Days 4 IF UNDER 24 HRS. Hours - Min. -

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Machinist

10b. KIND OF BUSINESS OR INDUSTRY: --- Unk-

11. BIRTHPLACE (State or foreign country): unknown

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) unknown (If Yes, give war or dates of service) ---

16. SOCIAL SECURITY No.: unknown

17. INFORMANT & ADDRESS: Records - Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death
Immediate cause	(a) Bronchial pneumonia	4 days
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	DUE TO (b) Cerebral thrombosis	8 days
331 (491X)	DUE TO (c) Arteriosclerosis with hypertension	over 1 yr.
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Psychosis with chronic alcoholism	over 1 year

19a. DATE OF OPERATION: ---
19b. MAJOR FINDINGS OF OPERATION ---
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) ---
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---
(CITY OR TOWN) ---
(COUNTY)
(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. ---
INJURY OCCURED While at Work ☐ Not While At Work ☐ ---
HOW DID INJURY OCCUR? ---

22. I hereby certify that I attended the deceased from Mar. 24, 1952, to Jan. 14, 1953, that I last saw the deceased alive on Jan. 14, 1953, and that death occurred at 12:38 p.m. from the causes and on the date stated above.

SIGNATURE (Degree or title) Martin Gross, M.D. ADDRESS Martin Gross, M. D. Sykesville, Md. DATE SIGNED 1/15/53

23. BURIAL, CREMATION, REMOVAL (Specify) Removal
DATE THEREOF 1/19/53
NAME OF CEMETERY OR CREMATORY University Med School
LOCATION (City, town, or county) (State) Balto City Md

DATE REC'D BY LOCAL REGISTRAR Jan. 19, 1953
REGISTRAR'S SIGNATURE C. Henry Beer
24. FUNERAL DIRECTOR Frances A. Hemeley
ADDRESS 578 W. Baltimore

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 23 1953
BUREAU V. S.

Item 9 Film G150 2/2/53 whw

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
   COUNTY: Carroll — MARYLAND
   CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town): Henryton
   LENGTH OF STAY (in this place): 2yrs. 9mos. 2das.
   HOSPITAL OR INSTITUTION OR STREET ADDRESS: HENRYTON STATE HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
   STATE: Maryland — COUNTY: Somerset
   CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crisfield
   STREET ADDRESS (If rural give location): Seventh & Paper Sts. ✓

3. NAME OF DECEASED: (First) HAZEL (Middle) HELEN (Last) BROWN
   (Type or Print)

4. DATE OF DEATH: (Month) January (Day) 5, (Year) 19 53

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Dec., 16, 1918

9. AGE last birthday: 34 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Crab-picker

10b. KIND OF BUSINESS OR INDUSTRY: Seafood House

11. BIRTHPLACE (State or foreign country): Crisfield, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Samuel Murril

14. MOTHER'S MAIDEN NAME: Carrie Pettit

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No
    (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: Unknown

17. INFORMANT & ADDRESS: Deceased

18. MEDICAL CERTIFICATION

		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause	(a) Far Advanced Bilateral Pulmonary Tuberculosis	Feb., 1949
Antecedent causes (s) Diseases or conditions, If any, giving rise to the above cause stating the underlying cause last.	DUE TO (b) and Diabetic.	
002 X 260X	DUE TO (c)	

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr. 3, 1950, to Jan. 5, 19 53, that I last saw the deceased alive on Jan. 5., 19 53., and that death occurred at 2:45 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): I.F. Vestal. M.D. — ADDRESS: Henryton, Maryland — DATE SIGNED: 1-5-53

23. BURIAL, CREMATION, REMOVAL, (Specify): Buried — DATE THEREOF: Sunday 11th 53 — NAME OF CEMETERY OR CREMATORY: Hopewell — LOCATION (City, town, or county) (State): Maryland, Crisfield

DATE REC'D BY LOCAL REGISTRAR: 1-5-53 — REGISTRAR'S SIGNATURE: Albert R. Swanbeck, Deputy Local

24. FUNERAL DIRECTOR — ADDRESS: Bradshaw Funeral Palace, Crisfield, Maryland

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 77

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY Canoel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hampstead
LENGTH OF STAY (In this place) 8 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Canoll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hampstead
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) ESTELLA (Middle) M (Last) BUELL

4. DATE OF DEATH: (Month) Jan (Day) 7 (Year) 1953

5. SEX: F. — 6. COLOR OR RACE: W — 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow — 8. DATE OF BIRTH: May 25 1869 — 9. AGE last birthday: 82 yrs. — If under 1 year: Months — Days — If under 24 hrs.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired — 10b. KIND OF BUSINESS OR INDUSTRY: Housework — 11. BIRTHPLACE (State or foreign country): Md — 12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Wesley Cullison — 14. MOTHER'S MAIDEN NAME: Rebecca Annacort

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO. — 17. INFORMANT AND ADDRESS: Mrs Virgil Naylor, Hampstead Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X

Immediate cause (a) Cerebral hemorrhage — Interval between onset and death: —

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arterio Sclerosis — Years.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE James T Shorb — (Degree or title) Deputy Medical Examiner — ADDRESS Westminster Md — DATE SIGNED 1/7/53

23. BURIAL, CREMATION REMOVAL (Specify) Burial — DATE THEREOF 1-9-53 — NAME OF CEMETERY OR CREMATORY Grace — LOCATION (City, town, or county) Bullo (State) Md

DATE REC'D BY LOCAL REG. 1/8/53 — REGISTRAR'S SIGNATURE Henry Lewis — 24. FUNERAL DIRECTOR Edw A Upton — ADDRESS Hampstead Md

JAN 1

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 76

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Carroll — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
LENGTH OF STAY (In this place) 3 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Hush Ave

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Union Bridge Rural
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) David (Middle) (Last) CASE
4. DATE OF DEATH: (Month) Jan (Day) 9 (Year) 1953

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
M	W	Single	6-2-1876	76 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farm Laborer - Unemployed
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME not known
14. MOTHER'S MAIDEN NAME not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS J. Wilbert Parrott 15 Hush Ave. Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Occlusion — None

420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis & V Disease — Years

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE James T. Nash (Degree or title) Deputy Medical Examiner ADDRESS Westminster Md. DATE SIGNED 1/9/53

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Jan. 12 1953	Meadow Branch Cemetery	Westminster	Md.

DATE RECD BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1/10/53	[signature]	H. Bankard & Son	Westminster, Md.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 137

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH: COUNTY Carroll (Frederick Co) STATE MARYLAND (Md)
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Union Bridge
LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Frederick
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) Elizabeth (Last) Cramer Clemson

4. DATE OF DEATH: (Month) 1 (Day) 14 (Year) 1953

5. SEX: F | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed | 8. DATE OF BIRTH: 1848 Nov 23 | 9. AGE last birthday: 104 yrs. | If under 1 year: Months / Days 2 | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country): Frederick Co Md | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: J Henry Cramer | 14. MOTHER'S MAIDEN NAME: Catherine Stringuel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT: Miss Bessie Clemson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

400.0

Immediate cause (a) Cerebral Sclerosis

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) /

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 6, 1952, to Jan 14, 1953, that I last saw the deceased alive on Jan 14, 1953, and that death occurred at 2.7 m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

J. H Legg MD Clemson Bridge 1-15-53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE 1-16-53 | NAME OF CEMETERY OR CREMATORY Mountain View | LOCATION (City, town, or county) Union Bridge. | (State) Md

DATE REC'D BY LOCAL REG. Jan 15 1953 | REGISTRAR'S SIGNATURE Chas H Lemmon | 24. FUNERAL DIRECTOR Raymond K. Wright | ADDRESS Union Bridge Md.

Leslie L. Repp Pmc

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH
COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster
LENGTH OF STAY (in this place) 4 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 20 Charles

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster
STREET ADDRESS (If rural, give location) 20 Charles

3. NAME OF DECEASED (Type or Print): (First) RONALD (Middle) LEE (Last) COOK

4. DATE OF DEATH: (Month) 1 (Day) 30 (Year) 1953

5. SEX: M

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Sept. 28-1948

9. AGE last birthday: 4 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Son

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Major Cook Jr.

14. MOTHER'S MAIDEN NAME: Catherine Moore

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Catherine Moore Cook 20 Charles St. Westminster Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Hydrocephalus

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) unknown

(c)

344

Interval between onset and death: about 4 yrs

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Rachitis

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 45, 19[illegible] to Jan. 29, 1953 that I last saw the deceased alive on about Nov. 15, 1952, and that death occurred at 8:00 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Reese Wilkens M.D. Westminster Jan 31 1953

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: Feb. 1-1953

NAME OF CEMETERY OR CREMATORY: Western Chapel Cemetery

LOCATION (City, town, or county) (State): Westminster, Md.

DATE REC'D BY LOCAL REG.: 1/3/53

REGISTRAR'S SIGNATURE: [illegible]

24. FUNERAL DIRECTOR ADDRESS: H. Bankard Son Westminster, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 50

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Carroll; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN New Windsor; LENGTH OF STAY (in this place) Lifetime; HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md; COUNTY Carroll; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN New Windsor; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) WALTER (Middle) LEE (Last) CRAWMER

4. DATE OF DEATH: (Month) Jan (Day) 27 (Year) 1953

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed

8. DATE OF BIRTH: Dec. 2-1870

9. AGE last birthday: 82 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Own farm

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: U. S. A.

13. FATHER'S NAME: William Crawmer

14. MOTHER'S MAIDEN NAME: Barbara (not known)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. —

17. INFORMANT AND ADDRESS: Harry Crawmer, New Windsor, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Artery disease — Occlusion

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

420

INTERVAL BETWEEN ONSET AND DEATH: Minutes

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19....., to ....., 19....., that I last saw the deceased alive on ....., 19....., and that death occurred at .....m., from the causes and on the date stated above.

SIGNATURE James T. Monk (Degree or title) Deputy Medical Examiner ADDRESS Westminster Md DATE SIGNED 1-27-53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF 1/29/53

NAME OF CEMETERY OR CREMATORY Winters Cemetery

LOCATION (City, town, or county) New Windsor (State) Md

DATE REC'D BY LOCAL REG. Jan 27/53

REGISTRAR'S SIGNATURE Emma D Bunnell Local Reg.

24. FUNERAL DIRECTOR D. D. Hartley & Sons

ADDRESS New Windsor, & Union Bridge, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 76

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Carroll MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville; LENGTH OF STAY (in this place) 35 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore; STREET ADDRESS (If rural give location) 1247 E. Lexington Street

3. NAME OF DECEASED: (First) IDA (Middle) — (Last) DEITCHES

4. DATE OF DEATH: (Month) Jan. (Day) 18 (Year) 1953

5. SEX: fem.

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): divorced

8. DATE OF BIRTH: ? ? 1880

9. AGE Last birthday: 72 or 73 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Russia

12. CITIZEN OF WHAT COUNTRY? not known

13. FATHER'S NAME: Not Known

14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO.: —

17. INFORMANT & ADDRESS: hospital records

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Occlusion DUE TO — Interval Between Onset And Death: hours

420.1

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) DUE TO

(c)

11 OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Schizophrenia, paranoid type 35 years

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 15, 1950, to Jan. 18, 1953, that I last saw the deceased alive on Jan 18, 1953, and that death occurred at 6 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Gertrud Sonnenfeld M.D. ADDRESS Springfield State Hospital Sykes. Md DATE SIGNED 1/18/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF Jan 22/1953 NAME OF CEMETERY OR CREMATORY BNAI ISRAEL CEMETERY LOCATION (City, town, or county) (State) Balto Md

DATE REC'D BY LOCAL REGISTRAR 1/21/53 REGISTRAR'S SIGNATURE a a Adelsberg 24. FUNERAL DIRECTOR Sol Levinson Bros. ADDRESS 1116 W North ave

VII. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sykesville
LENGTH OF STAY (in this place): 7 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sykesville
STREET ADDRESS (If rural give location): ----

3. NAME OF DECEASED: (First) Maud (Middle) -- (Last) DeVries
4. DATE OF DEATH: (Month) Jan. (Day) 18 (Year) 1953
5. SEX: Female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): widowed
8. DATE OF BIRTH: 11-21-77
9. AGE Last birthday: 75 yrs. IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Sykesville, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William Slack
14. MOTHER'S MAIDEN NAME: Emma Kay Steele
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) ----
16. SOCIAL SECURITY NO.: unknown
17. INFORMANT & ADDRESS: Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause (a) Diabetic ulcers — 3 mo
DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Diabetes — more than 7 mo
DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. senile psychosis, depression — 17 yrs.

19a. DATE OF OPERATION: ----
19b. MAJOR FINDINGS OF OPERATION: ----
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) ----
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ----
(CITY OR TOWN) ----
(COUNTY)
(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. ----
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR? ----

22. I hereby certify that I attended the deceased from 6-14-52, 19..... , to 1-18 , 19..53, that I last saw the deceased alive on 1-18-53, 19 , and that death occurred at 8:45 pm , from the causes and on the date stated above.
SIGNATURE AND (Degree or title) Gertrude M. Gross, M.D.
ADDRESS Sykesville, Md.
DATE SIGNED 1-18-53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 1-21-53
NAME OF CEMETERY OR CREMATORY Freedom
LOCATION (City, town, or county) (State) W. Sykesville, Md.
DATE RECD BY LOCAL REGISTRAR Jan. 20, 1953
REGISTRAR'S SIGNATURE C. Harry Weer
24. FUNERAL DIRECTOR AND ADDRESS Weyd-Haight - Sykesville, Md.
Luther A. Haight

Item 9 queried Film G150 1/26/53 whw

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

76

Reg. Dist. No. 744

1. PLACE OF DEATH
COUNTY Carroll — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Finksburg
LENGTH OF STAY (in this place) 1½ years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Finksburg Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Finksburg
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) AMANDA (Middle) (Last) DICUS

4. DATE OF DEATH: (Month) Jan (Day) 17 (Year) 1953

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Dec 2, 1867

9. AGE last birthday: 85 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Housewife

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Julius Rasch

14. MOTHER'S MAIDEN NAME: Augusta Rammoff

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no.

16. SOCIAL SECURITY NO.: nk

17. INFORMANT AND ADDRESS: Mrs Emily Klein 160 Bruce St Yonkers, N.Y.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Arteriosclerotic C-V disease — Interval between onset and death: years

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

422.1

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1952, to Jan 17, 1953, that I last saw the deceased alive on Jan 15, 1953, and that death occurred at 8 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
James T Harold	M.D.	Westminster Md	1/17/53

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan. 21. 1953	Mt. Carmel Cemetery	Thurmont. Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan 20 1953	Blanche S. Eyler	M. F. Creager & Son.	Thurmont. Md.
1/21/53			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Item 9 queried. See Filmg150 1/2d/65 ..hw

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 5a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH — COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: New Windsor Rural
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Wakefield

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: New Windsor Rural
STREET ADDRESS (If rural, give location): Wakefield

3. NAME OF DECEASED (Type or Print): (First) LUCY (Middle) L (Last) DULL
4. DATE OF DEATH: (Month) Jan (Day) 22 (Year) 1953

5. SEX: Female
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M
8. DATE OF BIRTH: 3/2/1879
9. AGE last birthday: 73 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: John Poole
14. MOTHER'S MAIDEN NAME: Margaret Garver

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY No.: none
17. INFORMANT AND ADDRESS: Harry Dull - New Windsor Rural

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) cardio vascular disease — about 3 years

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) arteriosclerosis — several years

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. acute respiratory infection (Virus) — about Jan. 10-53

19a. DATE OF OPERATION: none
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): no
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 10, 1953, to Jan. 23, 1953, that I last saw the deceased alive on Jan. 22, 1953, and that death occurred at 4:20 P m., from the causes and on the date stated above.

SIGNATURE: J. T. Billingslea — (Degree or title) M.D. — ADDRESS: Westminster, Md. — DATE SIGNED: 1-23-53

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: 1/25/53
NAME OF CEMETERY OR CREMATORY: Linganore Cem.
LOCATION (City, town, or county) (State): Unionville Maryland

DATA REC'D BY LOCAL REGISTRAR: Jan 23/53
REGISTRAR'S SIGNATURE: Grace L Burdette
24. FUNERAL DIRECTOR — ADDRESS: D D Hartzler & Sons New Windsor & Union Bridge, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville
LENGTH OF STAY (in this place) 4 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Washington
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown
STREET ADDRESS (If rural give location) - - -

3. NAME OF DECEASED: (Type or Print) (First) Charles (Middle) William (Last) Faith

4. DATE OF DEATH: (Month) Jan. (Day) 25 (Year) 19 53

5. SEX: M.

6. COLOR OR RACE: W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 7-12-1884

9. AGE last birthday: 68 yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Sandbagger

10b. KIND OF BUSINESS OR INDUSTRY: Unk -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Faith

14. MOTHER'S MAIDEN NAME: Emmy Currans

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) unk. (If Yes, give war or dates of service) -

16. SOCIAL SECURITY No.: Unk -

17. INFORMANT & ADDRESS: Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause (a) Myocardial infarction — Interval Between Onset And Death: 4 days

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Arteriosclerosis — over 5 yrs

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Psychosis with cerebral arteriosclerosis — over 6 yrs.

19a. DATE OF OPERATION: -

19b. MAJOR FINDINGS OF OPERATION -

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) -

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) - (CITY OR TOWN) - (COUNTY) - (STATE) -

TIME OF INJURY (Month) - (Day) - (Year) - (Hour) - m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR? -

22. I hereby certify that I attended the deceased from Sept. 20, 1950, to Jan. 25, 1953, that I last saw the deceased alive on Jan. 24, 1953, and that death occurred at 6:45 a.m., from the causes and on the date stated above.

SIGNATURE AND (Degree or title) Henrikas Armanavicius, M.D. ADDRESS Springfield State Hospital, Sykesville, Md. DATE SIGNED Jan. 28, 1953

Henrikas Armanavicius, M.D.

23. BURIAL, CREMATION, REMOVAL (Specify) Removal — DATE THEREOF 1/28/53 — NAME OF CEMETERY OR CREMATORY University Med. Dental Balto City — LOCATION (City, town, or county) Md. (State)

DATE REC'D BY LOCAL REGISTRAR Jan. 28, 1953 — REGISTRAR'S SIGNATURE C. Harry Ulrey

24. FUNERAL DIRECTOR AND ADDRESS Frances A. Hemsley 578 N. Biddle St.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY: Carroll — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural, Nr. Westminster
LENGTH OF STAY (in this place): Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Westminster, Md. R.D.1

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural, Nr. Westminster
STREET ADDRESS (If rural, give location): Westminster, Md. R.D.1

3. NAME OF DECEASED (Type or Print): (First) William (Middle) Franklin (Last) Feeser

4. DATE OF DEATH: (Month) 1/31/53 (Day) (Year) 19

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 8/6/1883

9. AGE last birthday: 69 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming (Retired)

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Carroll County, Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William H. Feeser

14. MOTHER'S MAIDEN NAME: Barbara Ellen Bachman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: 214-32-3899

17. INFORMANT AND ADDRESS: Mrs. Wm. F. Feeser Westminster, Md. R.D.1

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary Thrombosis	Several hrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic Myocarditis	Several yrs
	(c) Arterio Sclerosis	Several yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

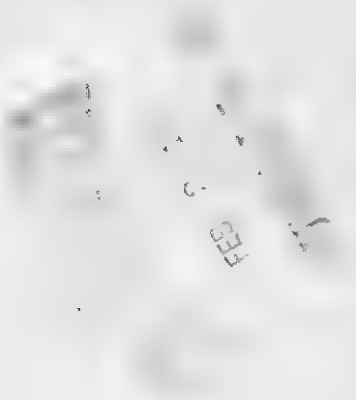
22. I hereby certify that I attended the deceased from Last, 1952, to Jan. 31, 1953 that I last saw the deceased alive on Jan 31, 1953, and that death occurred at 8:15 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Wm. F. Feeser — ADDRESS: Westminster — DATE SIGNED: Jan 1/31/53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — **DATE THEREOF**: 2/3/53 — **NAME OF CEMETERY OR CREMATORY**: St. Marys Union Cemetery — **LOCATION** (City, town, or county) (State): Silver Run, Carroll Co. Md.

DATE REC'D BY LOCAL REG.: 1/31/53 — **REGISTRAR'S SIGNATURE**: [illegible]

24. FUNERAL DIRECTOR — **ADDRESS**: John W. Littlestown, Littlestown, Pa.
Rev Richard A. Little



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

0034

Reg. Dist. No. ...

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS: A15

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville, Md.
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural give location) 4208 Springwood Avenue ✓

3. NAME OF DECEASED: (Type or Print) (First) Eva (Middle) ---- (Last) Fischer
4. DATE OF DEATH: (Month) 1 (Day) 21 (Year) 1953
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: 1-30-73
9. AGE Last birthday: 79 yrs. IF UNDER 1 YEAR Months ... Days ... IF UNDER 24 HRS. Hours ... Min. ...
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: ---- at home
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Charles Kesner
14. MOTHER'S MAIDEN NAME: Margaret Ott
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No
(If Yes, give war or dates of service) ----
16. SOCIAL SECURITY NO.: 215-03-9127
17. INFORMANT & ADDRESS: Hospital records.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			Interval Between Onset And Death
Immediate cause	(a) DUE TO	Cerebral hemorrhage	6 wks.
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. 331X	(b) DUE TO	Arteriosclerosis	10 yrs.
	(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic brain syndrome with senile brain disease with psychotic reaction — About 6 yrs.

19a. DATE OF OPERATION: ----
19b. MAJOR FINDINGS OF OPERATION ----
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) ----
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ----
(CITY OR TOWN) ---- (COUNTY) ---- (STATE) ----
TIME OF INJURY (Month) ---- (Day) ---- (Year) ---- (Hour) ---- m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR? ----

22. I hereby certify that I attended the deceased from 7-1- ,1950 , to 1-19- , 1953 , that I last saw the deceased alive on 1/19 , 1953 , and that death occurred at 5:55 A. M. , from the causes and on the date stated above.
SIGNATURE Walther H. Sonnenfeldt M.D. (Title) M.D. ADDRESS Springfield State Hosp. Sykesville DATE SIGNED 1-21-53

23. BURIAL, CREMATION, REMOVAL (Specify) burial
DATE THEREOF 1/23/53
NAME OF CEMETERY OR CREMATORY Parkwood Cemetery
LOCATION (City, town, or county) (State) Baltimore, Md.
DATE REC'D BY LOCAL REGISTRAR 1/22/53
REGISTRAR'S SIGNATURE A. W. Hedrick
24. FUNERAL DIRECTOR HENRY SANDER & SONS, INC.
ADDRESS BALTO., 13, MD. Henry F. Sander

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE, PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important, Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville
MARYLAND — LENGTH OF STAY (in this place) since 10/11/45
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Garrett
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Friendsville
STREET ADDRESS (If rural give location) ---

3. NAME OF DECEASED: (Type or Print) (First) William (Middle) Edgar (Last) FISHER

4. DATE OF DEATH: (Month) January (Day) 23 (Year) 1953

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: April 18, 1895

9. AGE last birthday: 57 yrs. IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS. Hours — Min. —

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Farm laborer

10b. KIND OF BUSINESS OR INDUSTRY: --- Agriculture

11. BIRTHPLACE (State or foreign country): Garrett Co.

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: George Fisher

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) ---

16. SOCIAL SECURITY No.: 215-140-491

17. INFORMANT & ADDRESS: Records - Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

241X

Immediate cause (a) Chronic myocarditis and myocardial degeneration — Interval Between Onset And Death: ½ year

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO (b) Bronchial asthma — more than 1 year

DUE TO (c) ---

II OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Paranoid condition — 8 yrs.

19a. DATE OF OPERATION: ---

19b. MAJOR FINDINGS OF OPERATION ---

20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) ---

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---

(CITY OR TOWN) (COUNTY) (STATE) ---

TIME OF INJURY (Month) (Day) (Year) (Hour) --- m.

INJURY OCCURED While at Work ☐ Not While At Work ☐ ---

HOW DID INJURY OCCUR? ---

22. I hereby certify that I attended the deceased from Sept. 1, 1947, to Jan. 22, 1953, that I last saw the deceased alive on Jan. 22, 1953, and that death occurred at 1:30 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Martin Gross, M.D. — ADDRESS Sykesville, Md. — DATE SIGNED 1/23/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 1-26-53 — NAME OF CEMETERY OR CREMATORY Oakland — LOCATION (City, town, or county) (State) Oakland, Garrett Md.

DATE REC'D BY LOCAL REGISTRAR Jan. 24, 1953 — REGISTRAR'S SIGNATURE C. Henry Deer

24. FUNERAL DIRECTOR Baldin Funeral Home — ADDRESS Oakland, Md.

VS. A15

RECEIVED
JAN 27 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 5X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 51

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville
LENGTH OF STAY (in this place) 20 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 3311 Edgerton Road ✓

3. NAME OF DECEASED: (Type or Print) (First) JANE (Middle) HEBB (Last) FORD

4. DATE OF DEATH: (Month) January (Day) 3 (Year) 1953

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: Nov. 17, 1879

9. AGE last birthday: 73 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Baltimore Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John Stephen Hebb

14. MOTHER'S MAIDEN NAME: Mary L. Heyer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT & ADDRESS: hospital records.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) Coronary occlusion	minutes
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) Coronary artery disease	5 days
	DUE TO (c) Hypertensive cardiovascular disease	13 years

420

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Involutional Psychosis — 20 years

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 15, 1950, to Jan. 3, 1953, that I last saw the deceased alive on Jan. 2, 1953, and that death occurred at 7:30 a.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED

Gertrud Sonnenfeld M.D. Springfield State Hospital Sykesville 1/3/53.

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF 1/5/53

NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery

LOCATION (City, town, or county) Md. (State) Baltimore, Md.

DATE REC'D BY LOCAL REG. 1/5/53

REGISTRAR'S SIGNATURE H W Redinel Donor

24. FUNERAL DIRECTOR ADDRESS

HENRY SANDER & SONS, INC. BALTO., 13, MD.

George J. Sander

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster — LENGTH OF STAY (In this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.D #3 Westminster

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster
STREET ADDRESS (If rural, give location) R.D #3 Westminster

3. NAME OF DECEASED (Type or Print): (First) Bessie (Middle) C (Last) Garrick

4. DATE OF DEATH: (Month) Jan (Day) 9 (Year) 1953

5. SEX: F. — 6. COLOR OR RACE: W — 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M — 8. DATE OF BIRTH: 11/2/1886 — 9. AGE last birthday: 66 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife — 10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Carroll Co Md — 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Josiah Trout — 14. MOTHER'S MAIDEN NAME: Lizzie Ann Hull

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If year, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT AND ADDRESS: Ira G. Garrick Westminster Md #3

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Myocarditis — 7 months

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Pulmonary fibrosis & Tuberculosis — 12 yrs ?

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct, 1952, to 9 Jan, 1953, that I last saw the deceased alive on 8 Jan, 1953, and that death occurred at 9:15 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

G. G. Tanavis M.D. — McSherrystown Pa — 10 Jan '53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE 1/12/1953 — NAME OF CEMETERY OR CREMATORY Black Rock Cemetery — LOCATION (City, town, or county) (State) Bridgeks Pa R.D. York Co

DATE REC'D BY LOCAL REG. Jan. 11/53 — REGISTRAR'S SIGNATURE Mrs. W.P.L. Donner

24. FUNERAL DIRECTOR — ADDRESS W.L. Freier Hanover Pa

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 71

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Carroll; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Uniontown; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Carroll; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Uniontown; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) G. (Middle) Fielder (Last) Gilbert

4. DATE OF DEATH (Month) (Day) (Year): January 28, 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: July 31, 1886

9. AGE last birthday: 66 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Banker

10b. KIND OF BUSINESS OR INDUSTRY: Banking

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Edwin G. Gilbert

14. MOTHER'S MAIDEN NAME: Catherine Garner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 218-01-3141

17. INFORMANT AND ADDRESS: Mrs. G. Fielder Gilbert, Uniontown, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Occlusion — Interval Between Onset and Death: few minutes

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cardio-Vascular disease — about 10 years

(c) —

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): no

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): —

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?: —

22. I hereby certify that I attended the deceased from Jan. 1st, 1947, to Jan. 28th, 1953, that I last saw the deceased alive on Jan. 26th, 1953, and that death occurred at 8:15 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

J. T. Billingslea, M.D. Westminster, Md. 1-28-53

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: Jan. 31, 1953

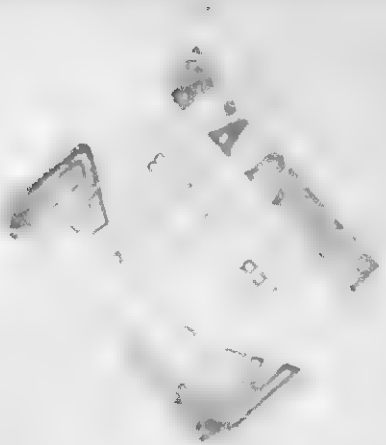
NAME OF CEMETERY OR CREMATORY: Church of God Cemetery

LOCATION (City, town, or county) (State): Uniontown, Maryland

DATE REC'D BY LOCAL REG.: Jan 29/53

REGISTRAR'S SIGNATURE: Margaret P. England

24. FUNERAL DIRECTOR ADDRESS: C.O. Fuss & Son, Taneytown, Maryland



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Carroll; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Manchester md; LENGTH OF STAY (in this place) 4 mo; HOSPITAL OR INSTITUTION OR STREET ADDRESS Towsen Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore; STREET ADDRESS (If rural, give location) 6023 Glyn oak Ave. Balto Md

3. NAME OF DECEASED (Type or Print): (First) Sara (Middle) Edna (Last) Giles

4. DATE OF DEATH: (Month) January (Day) 11 (Year) 1953

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 10-13-1883

9. AGE last birthday: 69 yrs. If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper

10b. KIND OF BUSINESS OR INDUSTRY: Hampden Storage Co.

11. BIRTHPLACE (State or foreign country): Baltimore Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward M Giles

14. MOTHER'S MAIDEN NAME: Emma Owings

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service) 188

16. SOCIAL SECURITY NO.: 212-09-9877

17. INFORMANT AND ADDRESS: Mrs Marie Giles; 3610 Sunkist Rd. Balto 6

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Primary Pneumonia Colon.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

INTERVAL BETWEEN ONSET AND DEATH: ?

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Hypertensive Cardio-Renal Vascular Disease ?

19a. DATE OF OPERATION —

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) —; PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY —; (CITY OR TOWN) —; (COUNTY) —; (STATE) —

TIME OF INJURY (Month) (Day) (Year) (Hour) —; INJURY OCCURRED While at Work ☐ Not While At work ☐; HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from May 26, 1952, to Jan 11, 1953, that I last saw the deceased alive on Jan 11, 1953, and that death occurred at 8 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Joel E Lusk md Hampstead Md 1-11-53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial; DATE THEREOF: 1-14-1953; NAME OF CEMETERY OR CREMATORY: Woodlawn; LOCATION (City, town, or county) (State): Woodlawn, Md.

DATE REC'D BY LOCAL REG. 1/13/53; REGISTRAR'S SIGNATURE: Dr. Helmick

24. FUNERAL DIRECTOR: G. Howard Strong; ADDRESS: 3207 W. North Ave.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 70

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville
LENGTH OF STAY (in this place) 12 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY ---
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS ??? (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Adam (Middle) ---- (Last) Gostomski

4. DATE OF DEATH: (Month) Jan. (Day) 16 (Year) 1953

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: August 7, 1891

9. AGE Last birthday: 61 yrs. IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: unemployed

10b. KIND OF BUSINESS OR INDUSTRY: ----

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Xavier Gostomski

14. MOTHER'S MAIDEN NAME: Rose Ziemba

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no — (If Yes, give war or dates of service) ---

16. SOCIAL SECURITY No.: ----

17. INFORMANT & ADDRESS: Records of Springfield State Hosp.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause (a) Coronary occlusion — Interval Between Onset And Death: 6 hrs

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Arteriosclerosis — 12 yrs

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Mental deficiency without psychosis about 6oyrs

19a. DATE OF OPERATION: ----

19b. MAJOR FINDINGS OF OPERATION ----

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) ----

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ----

(CITY OR TOWN) ---- (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) ---- m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR? ----

22. I hereby certify that I attended the deceased from Sept. 1, 1947, to Jan. 16, 1952, that I last saw the deceased alive on Jan. 16, 1953, and that death occurred at 9:23 p.m., from the causes and on the date stated above.

SIGNATURE Martin Gross (Degree or title) M.D. — ADDRESS Sykesville, Md. — DATE SIGNED 1-16-53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 1/20/53 — NAME OF CEMETERY OR CREMATORY St. Stanislaus — LOCATION (City, town or county) Baltimore (State) Maryland

DATE REC'D BY LOCAL REGISTRAR 1/19/53 — REGISTRAR'S SIGNATURE G. W. Hedrick

24. FUNERAL DIRECTOR M.F. SADOWSKI & SONS — ADDRESS 1808 EASTERN AVENUE

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 70

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Taneytown
LENGTH OF STAY (in this place): 50 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Taneytown
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Ember (Middle) Blanche (Last) Hockensmith

4. DATE OF DEATH: (Month) (Day) (Year) January 9, 1953 19

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Sept. 18, 1878

9. AGE last birthday: 74 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Penna.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Abram Waybright

14. MOTHER'S MAIDEN NAME: Rhodes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: Mr. John J. Hockensmith, Taneytown, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cardiac failure - acute — Interval between onset and death: 36 hrs.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
420.1
(b) Ventricular fibrillation?) —
(c) Coronary artery disease — 6 months

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 14 June, 1952, to 9 January, 1953 that I last saw the deceased alive on 9 January, 1953, and that death occurred at 3:40 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Walter E. Stevens M.D. — ADDRESS: Taneytown, Md — DATE SIGNED: 9 Jan '53

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: 1/12/53

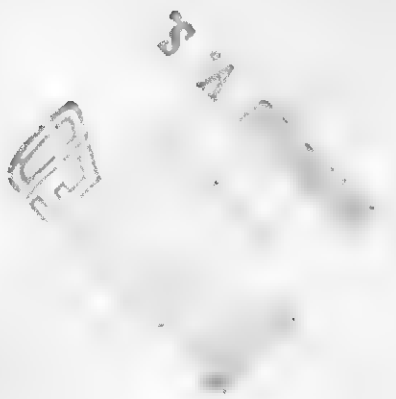
NAME OF CEMETERY OR CREMATORY: Lutheran Cemetery

LOCATION (City, town, or county) (State): Taneytown, Maryland

DATE REC'D BY LOCAL REG: Jan 9, 1953

REGISTRAR'S SIGNATURE: Ethel M Mehring Local Reg.

24. FUNERAL DIRECTOR / ADDRESS: C.O. Fuss & Son, Taneytown, Maryland



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The ... is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH: COUNTY Carroll; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster; HOSPITAL OR INSTITUTION OR STREET ADDRESS 174 Lincoln Rd. — ; STATE MARYLAND; LENGTH OF STAY (in this place) 18 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Carroll; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster — Rural; STREET ADDRESS (If rural, give location) 174 Lincoln Rd.

3. NAME OF DECEASED (Type or Print): (First) GEORGE (Middle) R. (Last) HOOK

4. DATE OF DEATH: (Month) Jan. (Day) 10, (Year) 1953

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: 4-5-1885

9. AGE last birthday: 67 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Dairy farm

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William Hook

14. MOTHER'S MAIDEN NAME: Mary Reese

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-14-6026

17. INFORMANT AND ADDRESS: Mrs. Minnie J. Hook, Same

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary Thrombosis	12 hrs.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic Myocarditis & Valvular Insufficiency	several yrs
420.1	(c) Arteriosclerosis	5 yrs.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec., 19.52, to Jan. 10 19.53 that I last saw the deceased alive on Jan. 9., 19.53, and that death occurred at 3:30 A.M., JAN. 10 53 from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Wilhelm Speicher Westminster Md Jan 10/53

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

DATE THEREOF: 1-13-1953

NAME OF CEMETERY OR CREMATORY: Westminster

LOCATION (City, town, or county) (State): Westminster, Md.

DATE REC'D BY LOCAL REG.: 1/12/53

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR ADDRESS: C. M. Waltz, Winfield, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Carroll MARYLAND; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville; LENGTH OF STAY (In this place) 42 years

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY -; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick

STREET ADDRESS (If rural give location) unknown ✓

3. NAME OF DECEASED: (Type or Print) (First) Robert (Middle) E. (Last) Hull

4. DATE OF DEATH: (Month) Jan. (Day) 18 (Year) 19 53

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 1872

9. AGE last birthday: 81 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Tel. operator

10b. KIND OF BUSINESS OR INDUSTRY: Tel. Co. -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel Hull

14. MOTHER'S MAIDEN NAME: Annie F. Barrick

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) unkn. (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Unk.

17. INFORMANT & ADDRESS: Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Myocardial Infarction — Interval Between Onset And Death: 4 days

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Myocardosis — about 4 yea rs

DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Schizophrenia paranoid type — over 42 years

19a. DATE OF OPERATION: - 19b. MAJOR FINDINGS OF OPERATION - 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) - PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) - (CITY OR TOWN) - (COUNTY) - (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) - m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR? -

22. I hereby certify that I attended the deceased from Sept. 1 1947, to Jan. 18, 1953, that I last saw the deceased alive on Jan. 17 1953, and that death occurred at 5:15 a.m. from the causes and on the date stated above.

SIGNATURE Martin Gross M.D. (Degree or title) Springfield State Hospital ADDRESS DATE SIGNED Jan 18-1953

Martin Gross, M.D.

23. BURIAL, CREMATION, REMOVAL (Specify) Burial; DATE THEREOF 1-20-53; NAME OF CEMETERY OR CREMATORY Springfield; LOCATION (City, town or county) Sykesville, Md. (State)

DATE REC'D BY LOCAL REGISTRAR Jan. 20, 1953; REGISTRAR'S SIGNATURE C. Harry Eckel

24. FUNERAL DIRECTOR Wm. J. Haight Sykesville, Md. ADDRESS

Walter J. Haight

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1114

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH: COUNTY Carroll; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster; LENGTH OF STAY (In this place) 50 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS 10 Ridge Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md; COUNTY Carroll; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster; STREET ADDRESS (If rural, give location) 10 [illegible]

3. NAME OF DECEASED (Type or Print): (First) Alvey (Middle) Michael (Last) Isanogle

4. DATE OF DEATH (Month) Jan. (Day) 27th. (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: Jun.6.1873

9. AGE last birthday: 79 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Teacher

10b. KIND OF BUSINESS OR INDUSTRY: W.M.College

11. BIRTHPLACE (State or foreign country): Frederick Co. MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Isanogle

14. MOTHER'S MAIDEN NAME: Matilda Bowers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO.: No

17. INFORMANT AND ADDRESS: Isabel T. Isanogle. 10 Ridge Rd.

18. MEDICAL CERTIFICATION: Westminster MD

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Acute Coronary Thrombosis — Interval between onset and death: 2 hrs.

420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/27, 1953, to 1/27, 1953, that I last saw the deceased alive on 1/27, 1953, and that death occurred at 3 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

[signature] W'Minster Md 1/27/53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: Jan.30.1953

NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

LOCATION (City, town, or county) (State): Cumberland Md

DATE REC'D BY LOCAL REG.: Jan.28.1953

REGISTRAR'S SIGNATURE: Blanche L. Eyler

1/30/53 [signature]

24. FUNERAL DIRECTOR: M. L. Creager & Son ADDRESS: Thurmont. MD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A1 -51

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Sykesville
LENGTH OF STAY (in this place) 36 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 1220 Mc. Culloh Street

3. NAME OF DECEASED: (First) SARAH (Middle) KATHERINE (Last) JAMES
4. DATE OF DEATH: (Month) Jan. (Day) 10 (Year) 1953

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
fem.	white	divorced	2 2 1870	83 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Harford County
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Herman Smith
14. MOTHER'S MAIDEN NAME: Annie Freeman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No
(If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: Unk
17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) Pulmonary embolus	hours
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) Thrombophlebitis of both legs	ill about for 2 years
DUE TO		
	(c) Generalized arteriosclerosis	14 years

458.0

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Schizophrenia, paranoid type — 36 years

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION: 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY — M. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 15, 19 50, to Jan 10, 19 53, that I last saw the deceased alive on Jan 9, 19 53, and that death occurred at 3 35 A.M., from the causes and on the date stated above.

SIGNATURE	(DEGREE OR TITLE)	ADDRESS	DATE SIGNED
Gertrud Sonnenfeld	M.D.	Springfield State Hospital	1/10/53

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Removal	1/13/53	University Med School	Balto City MD

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1-13-53	C. Harry Weed	Frances G Hensley	578 N Bridge St

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville Rural
LENGTH OF STAY (in this place) —
HOSPITAL OR INSTITUTION OR STREET ADDRESS Gaither Road

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville
STREET ADDRESS (If rural, give location) Gaither Road

3. NAME OF DECEASED: (Type or Print) (First) Wayne (Middle) Anthony (Last) Johnson

4. DATE OF DEATH: (Month) Jan. (Day) 21 (Year) 1953

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: 1/21/53

9. AGE last birthday: 0 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. 30

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Alexander Johnson

14. MOTHER'S MAIDEN NAME: Ruth Louise Luckenbaugh

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Ruth Louise Johnson, Sykesville

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause (a)	Dead before arrival of doctor, unbilled	30 min
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b)	DUE TO Cord around neck Caused suffocation	
(c)	DUE TO	

761.0

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — **19b. MAJOR FINDINGS OF OPERATION:** — **20. AUTOPSY?** Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/21/53, to 1/21/53 that I last saw the deceased alive on 1/21/53, and that death occurred at 7 a.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED
Dr. E. Martin M.D. Randallstown Md 1/21/53

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF 1-23-53 — NAME OF CEMETERY OR CREMATORY Mt Olivet — LOCATION (City, town, or county) (State) Hanover, Penna.

DATE REC'D BY LOCAL REG. Jan. 22, 1953 — REGISTRAR'S SIGNATURE C. Harry Weer — 24. FUNERAL DIRECTOR Reese Haight — ADDRESS Sykesville, Md

Linked H. Haight

1013296405

VS. A15 61

IAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 80

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH — COUNTY: Carroll — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: New Windsor — LENGTH OF STAY (In this place): 2 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: New Windsor
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) DAVID (Middle) (Last) LINDSAY

4. DATE OF DEATH: (Month) Jan. (Day) 11 (Year) 53

5. SEX: male | 6. COLOR OR RACE: white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): widowed | 8. DATE OF BIRTH: 7/26/1880 | 9. AGE Last birthday: 72 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer | 10b. KIND OF BUSINESS OR INDUSTRY: Day | 11. BIRTHPLACE (State or foreign country): Maryland | 12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Columbus Lindsay | 14. MOTHER'S MAIDEN NAME: Margaretanna Broom

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no | 16. SOCIAL SECURITY NO.: 214-03-1073 | 17. INFORMANT AND ADDRESS: Florence Lindsay New Windsor, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH: 7 days

Immediate cause (a) Cerebral Hemorrhage

331X

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/4/53, 19..., to 1/11/53, 19..., that I last saw the deceased alive on 1/11/53, 19..., and that death occurred at 8:30 A.m., from the causes and on the date stated above.

SIGNATURE: M. E. Robertson | (Degree or title): M.D. | ADDRESS: New Windsor | DATE SIGNED: 1/11/53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: 1/13/53 | NAME OF CEMETERY OR CREMATORY: Sixtus Cemetery | LOCATION (City, town, or county) (State): Taneytown, Md.

DATE REC'D BY LOCAL REG.: Jan 13/53 | REGISTRAR'S SIGNATURE: Grace L. Bucket

24. FUNERAL DIRECTOR: D. D. Hafinger & Sons | ADDRESS: Union Bridge & New Windsor, Md

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 50

1. PLACE OF DEATH: COUNTY Carroll; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN New Windsor; LENGTH OF STAY (in this place) 4 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Carroll; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN New Windsor; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) GWENDOLYN (Middle) C. (Last) WINDSAY

4. DATE OF DEATH: (Month) January (Day) 14 (Year) 1953

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: 9/11/1906

9. AGE last birthday: 46 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housekeeper

10b. KIND OF BUSINESS OR INDUSTRY: at home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Charles H. Westpendaluer

14. MOTHER'S MAIDEN NAME: Bertie Fritz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: Russell E. Windsay, New Windsor, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Ulcerative Colitis — Interval between onset and death: 1 year

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

517.1

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 9/16/52

19b. MAJOR FINDINGS OF OPERATION: Ulcerative Colitis

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 1, 1952, to Jan 14, 1953, that I last saw the deceased alive on Jan 14, 1953, and that death occurred at 1245 P m., from the causes and on the date stated above.

SIGNATURE: M. E. Robertson (Degree or title) M.D. ADDRESS: New Windsor, Md DATE SIGNED: 1/15/53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: 1/17/53

NAME OF CEMETERY OR CREMATORY: Pipe Creek Cem

LOCATION (City, town, or county) (State): Carroll County Md.

DATE REC'D BY LOCAL REG.: Jany 16/53

REGISTRAR'S SIGNATURE: Orner E Bowersox

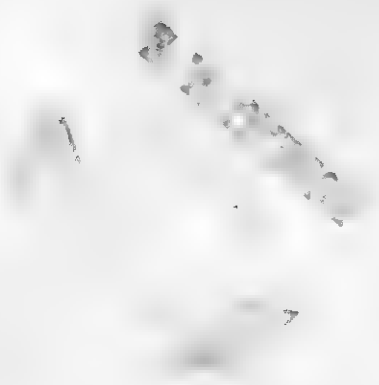
24. FUNERAL DIRECTOR: D. D. Hartzler & Sons

ADDRESS: New Windsor Md Union Bridge Md

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

(1936) Reg. Dist. No. 24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
   COUNTY CARROLL — MARYLAND
   CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN RURAL, SYKESVILLE
   LENGTH OF STAY (in this place) 10 days
   HOSPITAL OR INSTITUTION OR STREET ADDRESS SPRINGFIELD STATE HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
   STATE MARYLAND — COUNTY ALLEGANY
   CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
   STREET ADDRESS (If rural give location) 126 Polk Street ✓

3. NAME OF DECEASED: (Type or Print) (First) MARY (Middle) A. (Last) LIPPOLD

4. DATE OF DEATH: (Month) 1 (Day) 30 (Year) 1953

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED

8. DATE OF BIRTH: 1-13-83

9. AGE last birthday: 70 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: HENRY BROWN

14. MOTHER'S MAIDEN NAME: ELIZABETH BROWN

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO.: Unk —

17. INFORMANT & ADDRESS: HOSPITAL RECORDS

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cardiac failure; Left Ventricular rupture — Interval Between Onset And Death: 44 3t

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) DUE TO Hypertension
(c)

11 OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 21, 1953, to Jan. 30, 1953, that I last saw the deceased alive on Jan. 30, 1953, and that death occurred at 3 p.m., from the causes and on the date stated above.

SIGNATURE J. Bertner M.D. (Degree or title) — ADDRESS Springfield State Hospital, Sykesville, Maryland — DATE SIGNED 1/30/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 2-2-53 — NAME OF CEMETERY OR CREMATORY Cumberland — LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR Jan. 31, 1953 — REGISTRAR'S SIGNATURE C. Harry Uhler — 24. FUNERAL DIRECTOR Charles L. George — ADDRESS Cumberland, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 26

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Prince George's — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Jurisburg — LENGTH OF STAY (in this place) 8 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS Jurisburg Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. — COUNTY Prince George's
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Laurel
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
ARMSTEAD	ASHWORTHY	LUSK	Jan	12	1953

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
M	W	W	April 5 1880	72 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mail Carrier	Gov.	Princeton W. Va.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Wm. Bailey Lusk	Mary Jane Thurston

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
no	none	Randolph Lusk — Laurel, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Arteriosclerosis	years
331K Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cerebral Hemorrhage	1 day
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Dec, 1952, to Jan 12, 1953, that I last saw the deceased alive on Jan 11, 1953, and that death occurred at 8:30 a m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
James Thomas	M D	Washington DC	1/13/53

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	1-14-53	Medway Ridge	Washington Blvd Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1-13-53 / 1-19-53	[signature]	De Witt Woodson	Laurel, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY: CARROLL — MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN and give nearest town: RURAL, SYKESVILLE
LENGTH OF STAY (in this place): 3 mo. 7 da.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: SPRINGFIELD STATE HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: MARYLAND — COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town): BALTIMORE
STREET ADDRESS (If rural give location): 3401 Greenway, Eden Hall Apts. 4 D

3. NAME OF DECEASED (Type or Print): (First) LORETTA (Middle) JULIA (Last) MALONE

4. DATE OF DEATH: (Month) 1 (Day) 7 (Year) 1953

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE

8. DATE OF BIRTH: 8-17-90

9. AGE last birthday: 62 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): PIANIST

10b. KIND OF BUSINESS OR INDUSTRY: concert-self-empl

11. BIRTHPLACE (State or foreign country): CALIFORNIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: MICHAEL E. MALONE

14. MOTHER'S MAIDEN NAME: CATHERINE QUINN MALONE

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: HOSPITAL RECORDS

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Interval Between Onset And Death

Immediate cause (a) DUE TO: Coronary occlusion — minutes

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO: Hypertension - arteriosclerotic heart disease — indefinite

(c)

42 (260X)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Diabetes Mellitus; Schizophrenic reaction-chronic undifferentiated type — "

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 30, 19 52 to Jan. 7, 19 53, that I last saw the deceased alive on Jan. 7, 19 53 and that death occurred at 10:35 a.m. from the causes and on the date stated above.

SIGNATURE (Degree or title): Henry C. Mead, M.D. — ADDRESS: Springfield State Hospital, Sykesville Maryland — DATE SIGNED: 1-7-53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 1/9/53 — NAME OF CEMETERY OR CREMATORY: Carlsruhe — LOCATION (City, town, or county) (State): old Frederick Rd

DATE REC'D BY LOCAL REGISTRAR: 1/8/53 — REGISTRAR'S SIGNATURE: A. W. Hedrick M.D.

24. FUNERAL DIRECTOR: J J Fahey Sons — ADDRESS: 318 Light St.

Item 9 FilmC150 2/6/53 whw

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town): Sykesville, Maryland
LENGTH OF STAY (in this place): 11yrs. 5 mos
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location): Unknown ✓

3. NAME OF DECEASED: (First) Gertrude (Middle) ---- (Last) Meyers
4. DATE OF DEATH: (Month) 1 (Day) 29 (Year) 1953
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: Unknown
9. AGE last birthday: 70-75 yrs. ✓ IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY? ✓ Yank USA

13. FATHER'S NAME: Solomon Halsweig
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): Unk —
(If Yes, give war or dates of service): ----
16. SOCIAL SECURITY NO.: Unk -
17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
✗ Immediate cause	(a) Virus pneumonia	24 hrs.
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) Grippe	2 days
DUE TO		
	(c) Hypertensive cardiovascular disease	More than 12 yrs.

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Manic depressive psychosis, manic type — More than 30 yrs.

19a. DATE OF OPERATION: ----
19b. MAJOR FINDINGS OF OPERATION: ----
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) ----
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY ----
(CITY OR TOWN) ----
(COUNTY)
(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) M. ----
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR? ----

22. I hereby certify that I attended the deceased from 7-1-, 1950, to 1-29-, 1953, that I last saw the deceased alive on 1-29-, 1953, and that death occurred at 5:10 A.M., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS — DATE SIGNED
Walter H. Sonnenfeldt, M.D. Springfield State Hosp., Sykesville, Md. 1-29-53

23. BURIAL, CREMATION REMOVAL, (Specify): Burial
DATE THEREOF: 1-30-53
NAME OF CEMETERY OR CREMATORY: Herring Run
LOCATION (City, town, or county) (State): Balto Md.

DATE REC'D BY LOCAL REG.: Jan. 29, 1953
REGISTRAR'S SIGNATURE: C. Henry Wenz
24. FUNERAL DIRECTOR — ADDRESS: Jack Levin Inc. 2100 Eutaw Place

VS. A15 51

FEB 2
U. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. ...

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1 PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN Sykesville, Md. — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY [illegible]
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural give location) 612 William Street

3. NAME OF DECEASED: (Type or Print) (First) ANNIE (Middle) W. (Last) MOORE
4. DATE OF DEATH: (Month) January (Day) 8 (Year) 1953
5. SEX: Fem.
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): separated
8. DATE OF BIRTH: 5-12-1880
9. AGE last birthday: 72 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A
13. FATHER'S NAME: August WILDT
14. MOTHER'S MAIDEN NAME: Mathilda MILLER
15 WAS DECEASED EVER IN U.S ARMED FORCES? (Yes, no, or unk.) No — (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.:
17. INFORMANT & ADDRESS: Springfield State Hospital, Sykesville, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause — (a) DUE TO: Polycythemia, secondary to congestive heart failure — Interval Between Onset And Death: 4 months

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. — (b) DUE TO: hypertensive vascular disease — and over 4 months and longer

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Schizophrenia, paranoid type — Over 12 years

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 15, 1950, to Jan. 8, 1953, that I last saw the deceased alive on Jan. 8, 1953, and that death occurred at 10:30 P.M., from the causes and on the date stated above.

SIGNATURE Gertrude Sonnenfeld — (Degree or title) M.D. — ADDRESS Springfield State Hospital — DATE SIGNED 1/8/1953

23. BURIAL, CREMATION, REMOVAL (Specify) — DATE THEREOF 1/12/53 — NAME OF CEMETERY OR CREMATORY Western Run — LOCATION (City, town, or county) Baltimore Co. — (State) Md.

DATE REC'D BY LOCAL REGISTRAR January 10 1953 — REGISTRAR'S SIGNATURE R.W.

24. FUNERAL DIRECTOR J. T. STANBURY — ADDRESS 2706 Edmondson Ave.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

60367

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:

COUNTY Carroll — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sykesville, Md.

LENGTH OF STAY (in this place): 25yrs. 2mos.

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland — COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore

STREET ADDRESS (If rural give location): Unknown ✓

3. NAME OF DECEASED: (Type or Print) (First) Josephine (Middle) --- (Last) Moore

4. DATE OF DEATH: (Month) 1 (Day) 19 (Year) 1953

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Div.

8. DATE OF BIRTH: 4-21-1888

9. AGE last birthday: 64 yrs. IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Stanton, Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John W. Jenkins

14. MOTHER'S MAIDEN NAME: Isabelle Dorman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk (If Yes, give war or dates of service) ? ---

16. SOCIAL SECURITY No.: Unk —

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Interval Between Onset And Death

422.2

Immediate cause (a) ... Myocardial disease — 4 mos.

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Supparative parotitis — one week

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Chr. brain syndrome associated with conv. disorder with psychotic reaction.

19a. DATE OF OPERATION: ---

19b. MAJOR FINDINGS OF OPERATION ---

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) ---

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---

(CITY OR TOWN) ---

(COUNTY) ---

(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) ---

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR? ---

22. I hereby certify that I attended the deceased from 7-1-50, to 1-19-53, that I last saw the deceased alive on 1-18-53, and that death occurred at 2:00 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Walther H. Sonnenschein M.D. ADDRESS Springfield State Hospital - Sykesville DATE SIGNED 1-19-53

23. BURIAL, CREMATION, REMOVAL (Specify) Removal

DATE THEREOF 1/20/53

NAME OF CEMETERY OR CREMATORY University Medical School

LOCATION (City, town, or county) Baltimore City (State) Md

DATE REC'D BY LOCAL REGISTRAR Jan. 20, 1953

REGISTRAR'S SIGNATURE C. Harry Weed

24. FUNERAL DIRECTOR Frances G. Hemsley

ADDRESS 578 W Biddle St

JUN 23 1953

Item 7: film G150 1-21-53 LL

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 2X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Carroll. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville
LENGTH OF STAY (in this place) 25 days.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 312 S. Robinson Street.

3. NAME OF DECEASED (Type or Print): (First) Joseph (Middle) Charles (Last) Moser
4. DATE OF DEATH: (Month) Jan (Day) 1 (Year) 19 53

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	white	Married	6/28/12	65 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Elevator Operator
10b. KIND OF BUSINESS OR INDUSTRY: B&O. Train
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Moser
14. MOTHER'S MAIDEN NAME: Mary E Young.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): unknown
16. SOCIAL SECURITY NO.: 213-05-0628
17. INFORMANT AND ADDRESS: Hospital records.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
1130.1 Immediate cause	(a) Coronary occlusion	about 5 minutes
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis	2
(0.2X)	(c) Pulmonary tuberculosis	2

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic brain syndrome c arteriosclerosis of the brain, with psychosis — 2

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 12-7-, 19 52 to 1-1-, 19 53 that I last saw the deceased alive on 1-1-, 19 53 and that death occurred at 8 05 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Walther H. Sonnenfeldt M.D.	Springfield State Hospital	1/1/53

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	JAN. 5. 1953	Oak Forest Cemetery	Eastern Ave. Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1/5/53	D.D.R. Hedrick	Randall F. Kinzel	312 S. Highland Ave.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 70

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Rural- Taneytown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Rural Taneytown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Beulah M. Overholtzer

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Maurice M. Overholtzer
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 15, 1890

8. AGE: Years	Months	Days	If less than one day
62	7	28	....hrs. ....min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: Own Home

FATHER
12. Name: Charles D. Bankard
13. Birthplace: Penna.

MOTHER
14. Maiden name: Lydia J. Shoemaker
15. Birthplace: Maryland

16. Informant: Mr. Maurice Overholtzer
Address: Taneytown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: January 14, 1953 (month) (day) (year)
Cemetery or crematory: Reformed Cemetery
Location: Taneytown, Maryland

18. Funeral director: C. O. Fuss & Son
Address: Taneytown, Maryland

19. Jan 12, 1953 (Date rec'd by registrar) Ethel M Mehring Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 12, 1953, at 2:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 13, 1952, to January 12, 1953 and that I last saw h... alive on January 10, 1953

Immediate cause of death	DURATION
Fatty accumulation around her heart with heart oppression and effusion of lungs	
Due to: Cerebral Hemorrhage	
Due to:	
Other conditions: 331X	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. H. Legg M. D. or other
Address: Union Bridge Date signed: 1-12-53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 70

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN near Taneytown Md.
LENGTH OF STAY (in this place) Life time
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Taneytown
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) Martha (Middle) Alice (Last) Overholtzer

4. DATE OF DEATH: (Month) Jan. (Day) 1 (Year) 1953

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: Dec. 7, 1877

9. AGE last birthday: 75 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): house work

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Alfred Anders

14. MOTHER'S MAIDEN NAME: Mary Jane Heck

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no
(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT & ADDRESS: Mr. William Anders Taneytown, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Hemorrhage — 9 days

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
DUE TO (b) Arterio Sclerosis — 10 years
DUE TO (High Blood Pressure)
(c)

331 X

II. OTHER SIGNIFICANT CONDITIONS:
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) M.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 23rd 19.52, to Jan. 1st, 19.53., that I last saw the deceased alive on Dec. 31st., 19.52., and that death occurred at 1 A.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) C. M. Benner M.D. ADDRESS Taneytown maryland DATE SIGNED Jan. 3. 1953

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF Jan. 4, 1953
NAME OF CEMETERY OR CREMATORY Lutheran Cemetery
LOCATION (City, town, or county) (State) Taneytown, Maryland

DATE REC'D BY LOCAL REG. Jan. 3, 1953
REGISTRAR'S SIGNATURE Ethel M Mehring Local
24. FUNERAL DIRECTOR C.O.Fuss & Son, Taneytown, Maryland
ADDRESS

RECEIVED
JAN 8 1953

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 5X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville
LENGTH OF STAY (in this place) 11 mo 16 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore, 13.
STREET ADDRESS (If rural give location) 2332 Fairvale Street.

3. NAME OF DECEASED: (Type or Print) (First) Lottie (Middle) R. Charlotte (Last) Poole
4. DATE OF DEATH: (Month) 1 (Day) 2 (Year) 1953
5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): divorced
8. DATE OF BIRTH: 8/28/1872
9. AGE last birthday: 80 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: William T. Smith
14. MOTHER'S MAIDEN NAME: Elizabeth Thompson
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: none
17. INFORMANT & ADDRESS: Hospital records.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Myocardial disease DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Arteriosclerosis DUE TO

(c)

Interval Between Onset And Death: many years

422.1

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic bronchitis senile deliberation w. psychosis over 5 yrs

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan-17, 1952 to Jan-2 1953, that I last saw the deceased alive on Jan-2, 1953, and that death occurred at 12 00 midnight from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Walter A. Sonnenfeldt M.D Spring Field State Hospital 1/3/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF Jan 6th 1953 NAME OF CEMETERY OR CREMATORY Meadow mound Cemetery LOCATION (City, town, or county) Washington Blvd (State)

DATE REC'D BY LOCAL REGISTRAR 1/5/53 REGISTRAR'S SIGNATURE A. W. Hedrick

24. FUNERAL DIRECTOR Leo. J. Boucher ADDRESS 1703 N. Patterson Park Ave

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH: COUNTY Carroll; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster; LENGTH OF STAY (in this place) 2 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS R. D. 6

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE North Carolina; COUNTY Guilford; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN High Point; STREET ADDRESS (If rural, give location) 707 Dayton Street ✓

3. NAME OF DECEASED (Type or Print): (First) MATTIE (Middle) LEE (Last) REYNOLDS

4. DATE OF DEATH: (Month) Jan. (Day) 18 (Year) 1953

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 7-27-1904

9. AGE last birthday: 48 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Paper Box

10b. KIND OF BUSINESS OR INDUSTRY: Hosiery Silver Knit Mills

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Robert Wesley Causey

14. MOTHER'S MAIDEN NAME: Mary Thomas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 246-26-9345

17. INFORMANT AND ADDRESS: Mrs Charlie Waltz Westminster Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Thrombosis — Interval Between Onset and Death: 12 hrs

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Chronic myocarditis & Coronary Sclerosis — General 4 yrs

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 18, 1953, to Jan 18, 1953, that I last saw the deceased alive on Jan 18, 1953, and that death occurred at 8:00 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Wm Lem Speicher | ADDRESS Westminster Md | DATE SIGNED 1/20/53

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF Jan 21-1953 | NAME OF CEMETERY OR CREMATORY Westminster Cemetery | LOCATION (City, town, or county) Westminster (State) Md.

DATE REC'D BY LOCAL REG. 1/21/53 | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR H. B Ankard & Son | ADDRESS Westminster, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN New Windsor
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN New Windsor
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) CORA (Middle) A. (Last) RICHARDSON
4. DATE OF DEATH: (Month) Jan. (Day) 27 (Year) 19 53
5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: Mar. 12, 1867
9. AGE last birthday: 85 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Penna.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Ephraim Miller
14. MOTHER'S MAIDEN NAME: Susan Showalter
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS: Mr. E. Miller Richardson-New Windsor, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Acute Cerebral Hemorrhage — 10 hours

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chronic Arterio-Nephritis — 15 years

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/26, 1953, to 1/27, 1953, that I last saw the deceased alive on 1/27, 1953, and that death occurred at 5 P.M. m., from the causes and on the date stated above.

SIGNATURE Chester Bare (Degree or title) M.D. ADDRESS Westminster, Maryland DATE SIGNED 1/28/53

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	1/30/53	Winters Church Cem.	New Windsor, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1/30/53	[illegible]	Wm. J. Vickers & Sons	Balto. 17, Md.

Item 21 Film G151 3-3-53 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sykesville, Maryland
LENGTH OF STAY (in this place): MARYLAND 15yrs. 7mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland COUNTY: Frederick
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frederick, Md.
STREET ADDRESS (If rural give location): 229 West 5th St. ✓

3. NAME OF DECEASED: (Type or Print) (First) Emma (Middle) ---- (Last) Ridgeway

4. DATE OF DEATH: (Month) 1 (Day) 27 (Year) 1953

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 3-22-1880

9. AGE last birthday: 72 yrs. IF UNDER 1 YEAR: Months ---- Days ---- IF UNDER 24 HRS: Hours ---- Min. ----

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Housekeeper

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: J. W. Kohlenberg

14. MOTHER'S MAIDEN NAME: Ellen Trout

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) ----

16. SOCIAL SECURITY No.: Unk —

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

902.0
Immediate cause (a) DUE TO: Lobar pneumonia — Interval Between Onset And Death: 3 days

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) DUE TO: Fracture of right femur — 18 days ag
(c)

11 OTHER SIGNIFICANT CONDITIONS. Conditions contributing to the death but not related to the disease or condition causing death: Paranoid condition — More than 20 yrs.

19a. DATE OF OPERATION: ----

19b. MAJOR FINDINGS OF OPERATION ----

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Hospital (CITY OR TOWN) ---- (COUNTY) ---- (STATE) ----

TIME OF INJURY (Month) 1 (Day) 9 (Year) 53 (Hour) ---- m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR? Patient fell from her chair on the ward.

22. I hereby certify that I attended the deceased from 7-1- , 1950 , to 1-27- , 1953 , that I last saw the deceased alive on 1-26- , 1953 , and that death occurred at 1:20 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title): Walter H. Sonnenfeld — ADDRESS: Springfield State Hosp. Sykesville, Md. — DATE SIGNED: 1-27-53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 1-30 53 — NAME OF CEMETERY OR CREMATORY: Mt Olivet — LOCATION (City, town, or county) (State): Frederick, Md.

DATE REC'D BY LOCAL REGISTRAR: Jan. 28, 1953 — REGISTRAR'S SIGNATURE: C. Harry Eller

24. FUNERAL DIRECTOR ADDRESS: M. R. Eichelberger & Son, Frederick, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 1127

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 -51

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville — LENGTH OF STAY (in this place) 2 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 1135 W. Baltimore 1135 William Road

3. NAME OF DECEASED (Type or Print): (First) Vernon (Middle) Barton (Last) Rodgers

4. DATE OF DEATH: (Month) 1 (Day) 3 (Year) 1953

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: 5/5/1901

9. AGE last birthday: 51 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Warehouse employe

10b. KIND OF BUSINESS OR INDUSTRY: Work —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Charles Rodgers

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO.: Work —

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) Acute Myocarditis	recent 2
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) Pulmonary Tuberculosis	5 years
(0052)	DUE TO (c) Acute Brain Syndrome, alcoholic intoxication Delirium Tremens	ca. 3 days

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE) —

TIME OF INJURY (Month) (Day) (Year) (Hour) M. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 1/1, 19 53, to 1/3, 19 53, that I last saw the deceased alive on 1/3, 19 53, and that death occurred at 10 p.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED
Gertrude M. Gross (M. D.) Sykesville, Md. 1/3/53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF 1-6-53 — NAME OF CEMETERY OR CREMATORY Salem — LOCATION (City, town, or county) (State) Catonsville, Md

DATE REC'D BY LOCAL REG. 1-4-53 — REGISTRAR'S SIGNATURE C. Harry Ulrich — **24. FUNERAL DIRECTOR** Easton Ford — ADDRESS Catonsville 28, Md.

RECEIVED
JAN 6
BUREAU V.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH: COUNTY Carroll Co. MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Taneytown / LENGTH OF STAY (in this place) 25 yrs	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Taneytown
HOSPITAL OR INSTITUTION OR STREET ADDRESS Main St.	STREET ADDRESS (If rural, give location) Main St.

3. NAME OF DECEASED (Type or Print)	(First) Julius	(Middle) (N)	(Last) Sestili	4. DATE OF DEATH (Month) (Day) (Year)	January 12	1953	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.	
Male	White	Married	10/31/1878	74 yrs.			

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Shoe Worker	Shoe	Italy	U.S.

13. FATHER'S NAME Antonio Sestili	14. MOTHER'S MAIDEN NAME Lucia Segatti
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) / (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. —
17. INFORMANT AND ADDRESS Mrs. Lorraine Sestili Mc Cay, Linden St	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cachexia	15 days
MTX Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cardiac failure - chronic	3 months
	(c) Cancer of male genital organs - prostate	6 years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from October, 1947, to 12 January, 1953, that I last saw the deceased alive on January 3, 1953, and that death occurred at 3:00 P.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Walter E. Stevens	M.D.	Taneytown Md.	12 Jan 53

23. BURIAL, CREMATION / REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	1/15/53	Mt. Calvary Cem.	Uniontown Md.
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1/12/53	Dan Hedrick	Hudson Motter Funeral Service	Taneytown Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 ( )

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:

COUNTY: CARROLL — MARYLAND

CITY (If outside corporate limits, write RURAL) OR TOWN: RURAL, SYKESVILLE

LENGTH OF STAY (in this place): 6 Months

HOSPITAL OR INSTITUTION OR STREET ADDRESS: SPRINGFIELD STATE HOSPITAL

2 USUAL RESIDENCE (HOME) OF DECEASED:

STATE: MARYLAND — COUNTY: MONTGOMERY

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: KENSINGTON

STREET ADDRESS (If rural give location): 3909 Saul Street ✓

3. NAME OF DECEASED: (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH:	(Month)	(Day)	(Year)
	OLIVE	—	SHARP		1	28	19 53

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
FEMALE	WHITE	WIDOW	9-11-62	90 yrs.				

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Homemaker, retired	Own Home	Maryland	U. S. A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
John Daughtery	Emily Mc Coy

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
Yes —	none	HOSPITAL RECORDS

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Interval Between Onset And Death

Immediate cause (a) DUE TO: Chronic Myocardial Fibrosis

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO: Arteriosclerosis — Years

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Senile psychosis, — Years

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURED While at Work ☐ Not While At Work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from July 26, 1952, to Jan. 28, 1953, that I last saw the deceased alive on Jan. 28 1953, and that death occurred at 8:55 a.m. from the causes and on the date stated above.

SIGNATURE (Degree or title): Irene L. Hitchman, M. D. — ADDRESS: Springfield State Hospital, Sykesville, Maryland — DATE SIGNED: 1-28-53

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Cremation	Jan. 29, 1953	Fort Lincoln Cremetory	Prince Geo. Co.,	Md.

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24 FUNERAL DIRECTOR	ADDRESS
Jan. 29, 1953	C. Harry Weed	Warner E. Pumphrey,	Silver Spring, Md.

FEB 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6037

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 51

1. PLACE OF DEATH:
COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Sykesville
LENGTH OF STAY (In this place): 6 mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Md. COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Sykesville
STREET ADDRESS (If rural, give location): Near Bamber

3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print): MARY EMMA SHIPLEY

4. DATE OF DEATH: (Month) (Day) (Year): January 13, 1953

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 2/23/1877

9. AGE last birthday: 75 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Deckebaugh

14. MOTHER'S MAIDEN NAME: Mary L. Fox

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No. (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: B. M. Shipley, Rd, Sykesville, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

INTERVAL BETWEEN ONSET AND DEATH

151 Immediate cause (a) Carcinoma of stomach

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19~~51~~, to 1/12/, 1953, that I last saw the deceased alive on 1/12/, 1953, and that death occurred at 12:30 P.M., from the causes and on the date stated above.

SIGNATURE: Wm. E. Martin, M.D. (DEGREE OR TITLE) ADDRESS: Randallstown Md DATE SIGNED: 1/13/53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: 1/16/53

NAME OF CEMETERY ~~OR CREMATORY~~: Westminster

LOCATION (City, town, or county) (State): Westminster, Maryland

DATE REC'D BY LOCAL REG.: 1-15-53

REGISTRAR'S SIGNATURE: C. Harry Weaver

24. FUNERAL DIRECTOR ADDRESS: C. M. Waltz, Winfield, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. ....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sykesville
LENGTH OF STAY (in this place): 2½ months
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: ---
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
STREET ADDRESS (If rural give location): 1117 Ensor St. ✓

3. NAME OF DECEASED: (Type or Print) (First): Jake or Jacob (Middle): ---- (Last): Solinsky
4. DATE OF DEATH: (Month) Jan. (Day) 23 (Year) 1953

5. SEX: male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single
8. DATE OF BIRTH: ????
9. AGE last birthday: ? 62 ? yrs. IF UNDER 1 YEAR: Months | Days; IF UNDER 24 HRS: Hours | Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): ???
10b. KIND OF BUSINESS OR INDUSTRY: ---
11. BIRTHPLACE (State or foreign country): ???? U.S.A.Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ????
14. MOTHER'S MAIDEN NAME: ????

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): unk.
(If Yes, give war or dates of service): ----
16. SOCIAL SECURITY No.: ????
17. INFORMANT & ADDRESS: Records of Springfield State Hosp.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

025X
Immediate cause (a) General paresis ..... more than 7 mo.
DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) Syphilis ..... many years ?
DUE TO
(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: ---
19b. MAJOR FINDINGS OF OPERATION: ---
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): ----
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ---
(CITY OR TOWN): ----
(COUNTY)
(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.: ----
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR? ----

22. I hereby certify that I attended the deceased from Jan. 16, 1953, to Jan. 23, 1953, that I last saw the deceased alive on Jan. 23 1953, and that death occurred at 5:50 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Martin Gross, M.D.
ADDRESS: Sykesville, Md.
DATE SIGNED: Jan.23,1953

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: 1/25/53
NAME OF CEMETERY OR CREMATORY: Hebrew Friendship
LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE REC'D BY LOCAL REGISTRAR: January 24 1953
REGISTRAR'S SIGNATURE: R.W.
24. FUNERAL DIRECTOR: Sol Levinson Bros.
ADDRESS: 1124-26 W. North Avenue

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY CARROLL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN RURAL, SYKESVILLE
LENGTH OF STAY (In this place) 12 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS SPRINGFIELD STATE HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY WASHINGTON
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SMITHBURG
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) KATIE (Middle) ELIZABETH (Last) TRITAPOE

4. DATE OF DEATH: (Month) 1 (Day) 23 (Year) 1953

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOWED

8. DATE OF BIRTH: 9-9-77

9. AGE Last birthday: 75 yrs. If under 1 year: Months Days. If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): MARYLAND Fred. Co.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jacob F. Tritapoe

14. MOTHER'S MAIDEN NAME: Charlotte E. — ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk (If Yes, give war or dates of service) —?

16. SOCIAL SECURITY No.: Unk-

17. INFORMANT & ADDRESS: HOSPITAL RECORDS

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

33IX

Immediate cause (a) Cerebral hemorrhage DUE TO — Interval Between Onset And Death: hours

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Arteriosclerosis DUE TO — years

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic brain syndrome, associated with cerebral arteriosclerosis — years

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-12 ,1953, to 1-23 , 1953, that I last saw the deceased alive on 1-23- , 1953, and that death occurred at 3:55 a.m., from the causes and on the date stated above.

SIGNATURE AND TITLE Irene L. Hitchman, M.D. ADDRESS DATE SIGNED

Irene L. Hitchman, M. D. Springfield State Hospital, Sykesville, Md. 1-23-53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 1-25-53 — NAME OF CEMETERY OR CREMATORY Lutheran Cemetery — LOCATION (City, town, or county) (State) Middletown Md.

DATE REC'D BY LOCAL REGISTRAR Jan. 24, 1953 — REGISTRAR'S SIGNATURE C. Harry Weer

24. FUNERAL DIRECTOR Scott F. Minnich — ADDRESS Boonsboro

RECEIVED
JAN 27 1953
BUREAU V.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 0381

CERTIFICATE OF DEATH

Reg. Dist. No. 24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 51

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville
LENGTH OF STAY (in this place) 40 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) Unknown ✓

3. NAME OF DECEASED: (Type or Print) (First) Blanche (Middle) — (Last) Wallace

4. DATE OF DEATH: (Month) Jan. (Day) 28, (Year) 19 53

5. SEX: female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: unknown

9. AGE last birthday: about 72 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): unknown

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO.: none

17. INFORMANT & ADDRESS: Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) Bronchopneumonia	3 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) DUE TO Fungate carcinoma, left breast	3½ years
	(c) DUE TO	

170+

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Mental Deficiency, familial, moderate — Since birth

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M. —

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from Sept. 15, 19 50, to Jan. 28, 19 53, that I last saw the deceased alive on Jan. 27, 19 53, and that death occurred at 4:40 a.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED
Gebrud Sonnenfeld M.D. Springfield State Hospital, Sykesville Md. Jan. 28 1953

23. BURIAL, CREMATION / REMOVAL (Specify): Removal

DATE THEREOF 1-28-53

NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.

LOCATION (City, town, or county) (State) 1217 W. Pratt St. Balto. Md.

DATE REC'D BY LOCAL REG. Jan. 28, 1953

REGISTRAR'S SIGNATURE C. Henry Wm

24. FUNERAL DIRECTOR Wm Cook, Inc. ADDRESS 1217 W. Pratt St. Balto. Md.

RECEIVED
FEB 2 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

00382

Reg. Dist. No. 76

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH: COUNTY Carroll; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster 5; LENGTH OF STAY (In this place) 92 YRS. MARYLAND; HOSPITAL OR INSTITUTION OR STREET ADDRESS R.D. 5

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Carroll; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster; STREET ADDRESS (If rural, give location) R.D. 5

3. NAME OF DECEASED (Type or Print): (First) LAURA (Middle) ROBERTA (Last) YOUNG

4. DATE OF DEATH (Month) (Day) (Year): JAN. 3 1953

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: JUNE 18 1860

9. AGE last birthday: 92 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lewis Formwalt

14. MOTHER'S MAIDEN NAME: Elizabeth Myers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: Charles W. Young Taneytown, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Arteriosclerotic Cardio Vascular Disease

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

4-22-1

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/29/52, 19..., to 1/3/53, 1953, that I last saw the deceased alive on 1/1/53, 19..., and that death occurred at 8:15 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
M. E. Robertson	M D	New Windsor, Md	1/3/53

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	JAN. 6-1953	Bridge Cemetery	Westminster	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1/5/53	[signature]	H. Bankard & Son	Westminster, Md.

RECEIVED
JAN 7 1933
BUREAU V. S.